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ABSTRACT

A report of the 1981 Health Manpower Development Medium-Term Programme, sponsored by the World Health Organization's (WHO) Regional Office for Europe, is presented. The document "European Regional Strategy for Attaining Health for All by the Year 2000" was reviewed, and attention was directed to the present structure of the Regional Office for Europe and ways of implementing European regional programs at the national level. Discussions centered on the need for WHO to achieve a better balance between the earlier policy of assisting countries to increase supply and a more recent policy of producing relevant types of medical, nursing, and other health care that addresses social and economic realities. In an outline of the main features of the global medium-term program, the significance of global targets was stressed. Additional areas of consideration include the following: the development of the medium-term program on health manpower development (MTP/HMD); HMD/MTP activities during 1978-81; activities projected in the HMD/MTP for 1982-83; pproposed activities under the "Seventh General Programme of Work (1984-89)," with particular attention to 1984-85; machinery for implementation of the HMD program; the Association for Medical Education in Europe; the Association of Medical Deans in Europe; and the Association of Schools of Public Health in Europe. The status of the following subprograms for 1978-81 are also reviewed: communication and collaboration, continuing education of health personnel, teacher training for the health professions, and training of public health officers. The committee's recommendations for the overall program and separate subprograms and lines of development for 1984-89 are included. (SW)

THIRD ADVISORY COMMITTEE ON THE HEALTH MANPOWER DEVELOPMENT MEDIUM-TERM PROGRAMME

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Report

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Report

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1. Introduction

The meeting was opened by Dr J.E. Asvall, Director, Programme Management, on behalf of the Regional Director, Dr Leo A. Kaprio. In his address of welcome, Dr Asvall noted that the participants were drawn from a wide range of institutions and professions dealing with health manpower development issues: coming from ministries of health and social affairs and institutes for medical education and research and including teachers in the medical and health professions, community and primary health care and nursing. Nongovernmental organizations working in close cooperation with the Regional Office were also well represented: the Association for Medical Education in Europe (AMEE), the Association of Medical Deans in Europe (AMDE) and the Association of Schools of Public Health in the European Region (ASPHER).

Dr Asvall spoke of the European regional strategy for attaining health for all by the year 2000, adopted by the Regional Committee for Europe at its thirtieth session, held in Fez in 1980 (EUR/RC30/8), and of practical implications arising from the strategy. In addition, the various programme areas were identified in the regional contribution to the Seventh General Programme of Work covering a specific period (1984-1989) (EUR/RC31/7), which had been agreed upon by the Regional Committee at its thirty-first session in Berlin in 1981. Together, these policy statements marked out the general direction which health manpower development (HMD) should follow.

Three tasks for the Advisory Committee were identified:

(1) to review and evaluate progress in the medium-term health manpower development programme to date, including progress relating to recommendations by the Second Advisory Committee in 1978;

(2) to recommend approaches that would promote and support implementation of the programme already budgeted for 1982 and 1983 (the last two years of the Sixth General Programme of Work (EUR/RC30/6);

(3) to consider and advise the Regional Office on the relevance and priorities in the elaboration of its medium-term health manpower development programme for the Seventh General Programme of Work (ICP/PPM 003(2)). Within this six-year period, particular attention should be paid to the plan for the first two years (1984 and 1985) and attempts should be made to identify potential sources of support and means of securing maximum collaboration at national country level.

Professor Vanha-Perttula (Finland) was elected Chairman and Professor Vartanian (USSR) Vice-Chairman, a proposal by Dr Asvall. Dr Macara (United Kingdom) agreed to act as Rapporteur.

2. The background and context of the meeting

The present structure of the Regional Office was described with the functional relations existing between the Research, Planning and Human Resources Service and the five other services being outlined, together with the planning process adopted by the Regional Office to prepare the programme for the Seventh General Programme of Work and ways of implementing European regional programmes at the country level.

The European regional strategy for attaining health for all by the year 2000 (HFA2000) should be understood in the light of the global situation, i.e. the oil crisis, the growing gap between developed and developing countries, and increasing dissatisfaction with health services, which had led the Thirtieth World Health Assembly in 1977 to adopt resolution WHA30.43 on attaining the goal of HFA2000 so that people might live socially and economically productive lives. Though the HFA2000 concept had different meanings in different parts of the world, there was recognition of a common need to make the best use of available resources, to find better methods of prevention to improve the quality of life, to mobilize public opinion and to support this goal. The International Conference on Primary Health Care in Alma-Ata in 1978 had laid the ideological groundwork on which individual countries could develop relevant health programmes. Finally, in November 1979, the General Assembly of the United Nations had adopted a resolution calling on Member States and specialized agencies of the UN to support the HFA2000 goal by every available means, giving a coordinating role to the World Health Organization.

The European regional strategy has three main programme components:

(a) promotion of lifestyles conducive to health;
(b) reduction of preventable conditions;
(c) extension and reorientation of health care.

"Lifestyle" implies concern with the total environment and is clearly multisectoral; there is special concern in this area with motivating people and mobilizing resources towards self-help and with minimizing self-imposed risks by modifying attitudes and behaviour. "Prevention" means action to combat factors which have a harmful effect upon health, e.g. preventable genetic and perinatal risks, communicable diseases susceptible to immunization, accidents in the home, at work and play, poor nutrition and specific environmental hazards such as toxic chemicals. The "reorientation of health care systems" aims at stressing and developing primary health care in a manner designed to ensure full community participation in a spirit of self-reliance and providing health care of a type that is accessible to all individuals and families.

The following principles lie behind the programme area on health care: it should be better related to the needs of the population; consumers should participate, individually and collectively, in the planning and implementation of health care; the fullest use should be made of available resources; primary health care (PHC) is not an isolated approach but the segment of a comprehensive health system with greatest impact at local level.

Under the terms of the regional strategy so far as the health manpower development programme was concerned, there was a major need for joint health manpower and health services planning. In addition, particular concern was expressed over excess manpower in some categories of health care personnel and shortages in other categories, over the poor or inadequate distribution of resources, and over excessive specialization. To a large extent, the problems stem from a lack of collaboration between those responsible for education and training and those responsible for the management of health personnel.

Discussions centred on the need for WHO to strike a better balance between the earlier policy of quantity (assisting countries to increase supply) and a policy of quality (producing relevant types of medical, nursing and other categories of health care personnel) to meet the need for an "intersectoral" strategy related to social and economic realities. The importance of such a strategy was reinforced by the fact that manpower problems were not confined to the health sector. Action was urgently needed because the timescale meant that the consequences of current mistakes, e.g. excessive intake into medical schools, would still be felt in ten years' time.

In an outline of the main features of the global medium-term programme, the significance of global targets was stressed. Although these were not equally relevant to all the regions, they would permit an evaluation to be made of health manpower developments on a global scale. The outline included a presentation of the main lines of development in the preparation of the global health manpower development medium-term programme for the Seventh General Programme of Work.

3. Review of development of the medium-term programme on health manpower development (MTP/HMD) and recommendations made by the previous meeting of the Advisory Committee (Copenhagen, June 1978)

In this review, it was pointed out that the European Region had been the first of the WHO regions to set out priorities for a long-term programme for education and training, these originally being approved by the Regional Committee for Europe in 1972 (EUR/RC22/R5). The steering committee on the subject that met in 1976 (ICP/HMD 038) reviewed the health manpower development programme, recommended modifications and proposed programme priorities for the Regional Office's medium-term programme for the period 1976-1980.

A second meeting of the Advisory Committee on the Health Manpower Development Medium-Term Programme was convened in Copenhagen in June 1978. This committee reviewed the health manpower development programme priorities and advised how the regional medium-term programme in health manpower development (MTP/HMD) could be incorporated into the global programme (document A31/18) foreseen for the Sixth General Programme of Work (1978-1983) under the following three programme headings: manpower planning and management, promotion, and training and educational development and support, with 11 global "targets" (areas of work). The revised European regional part of the medium-term programme in health manpower development contained the following major lines of development:

- communication and collaboration between and within systems for the education of health personnel and the organization of health services;
- continuing education of health personnel;
- teacher training for the health professions;
- training of public health officers.

The comprehensive report of the second meeting of the Advisory Committee indicated priorities and contained recommendations for implementation in the light of existing financial constraints.

4. Review and evaluation of HMD/MTP activities during the period 1978-1981

Under the lines of development for the Regional Office HMD programme presented above, four evaluation reports on activities carried out during the previous four years were presented. A fifth item, the medium-term programme in nursing (1978-1983), was presented as part of the global MTP/HMD.

(a) Communication and collaboration

The main aim of this subprogramme was to stimulate Member States to overcome the gaps in communication and collaboration between and within the health and educational systems. The gaps result in unsatisfactory planning for the health professions and training, making these activities very often irrelevant to the real needs of the health services.

The programme began in 1974 with a meeting of deans, teachers in medical schools and senior administrators. The next step was a study carried out by the Swiss Federal Health Service, in collaboration with the Institute for Research in Medical Education and Evaluation, Berne, which focused on communication and collaboration mechanisms in order to identify channels of communication and machinery for policy implementation at ministerial and provincial levels. The study group held two meetings in 1977 and 1978 and prepared reports which described existing machinery and pointed out the needs to simplify it.

Another study, on communication and collaboration between physicians, nurses and medical social workers, completed in 1978 and based on observations made during visits to eight health centres in five countries, was used as the main background document for the Working Group on Working Interrelationships in the Provision of Community Health Care (Florence, October 1978).

A number of case studies demonstrating different machinery for communication and collaboration at governmental and institutional level, accompanied by a review of WHO resolutions and recommendations in this field, were prepared for a Working Group on Communication and Collaboration between and within the Health and Educational Systems held two years later (Warsaw, November 1980). That working group reviewed work by the Regional Office on the promotion of communication and collaboration and discussed ways of improving the machinery to strengthen such cooperation at different organizational levels of medical education and the health services.

The discussion showed that in some countries, Norway for example, although health services consumed 9% of the GNP, primary health care received only 10% of the budget. One difficulty was that reports and programmes prepared by WHO on health manpower development were not widely known at country level, indicating a failure in proper communication between WHO and Member States. Another problem in Norway was the failure by the health and educational sectors to collaborate and communicate properly with one another, as exemplified by the fact that the medical schools, with the exception of the one at Tromsö, had not been preparing doctors for general practice, although the general policy was to shift resources to primary health care with community involvement by placing responsibility for health services on the local authorities. The need to curtail the alarming growth in costs made assessment of needs (as distinct from demands) vital. Although it appeared that the numbers of doctors and nurses in training should be reduced or frozen, the numbers needed for other categories of health personnel, e.g. physiotherapists, were not known.

The discussions indicated that the Norwegian experience was not unusual. Apart from Finland, where effective mechanisms existed, it was not clear how much collaboration (if any) there was between ministries of health and education. However, it was clear that the ability to control the planning and distribution of health personnel was related to whether the ministry of health had any substantial influence on the education of medical and health personnel. Experience also showed that it was possible to promote neglected or underestimated specialties, such as general practice and community medicine (social and preventive medicine), by enhancing their educational status.

Despite evidence of growing interest in many Member States, the development of proper collaboration and some useful studies made by EURO, the impact of the regional activities still depended greatly on whether health and education ministries were interested in communicating with each other. Unfortunately, many WHO publications failed to pass from ministerial level to those at national level who ought to be concerned. At the same time, it was stressed by participants that dissemination of information was the mutual responsibility of WHO and of programme managers and institutions in the individual countries. Nongovernmental organizations, such as AMDE, AMFE and ASPHER, could be very useful in helping to expand channels of communication at country level.

(b) Continuing education of health personnel

The Committee's review of the development of the European regional programme stressed the importance of the Working Group on Continuing Education of Health Personnel (Dublin, October 1976), which had unequivocally declared competence to be the major purpose of continuing education, had defined the scope of the latter and had applied a comprehensive systems analysis approach to the subject. "Continuing education as a factor in the career development of health personnel" had been the theme of a Working Group held in Budapest in late October 1978, which had viewed continuing education as an integral part of employment and had called for the widest possible range of resources to be used in providing it. The technical discussions at the twenty-ninth session of the Regional Committee for Europe, held in Helsinki in 1979, had supported the thesis that the legitimate objective of continuing education was to raise the quality of health care rather than to meet the interests of professional groups and academic disciplines. At that Regional Committee session, it was stressed that an evaluation of the performance of those taking part in continuing education was crucial. This theme had been pursued at a meeting in Prague in September 1981, which had called for research into priorities, methods (including self-learning) and the use of indicators in evaluation. A Seminar on the Continuing Education of Health Workers in Primary Health Care (San Remo, October 1981) had studied the use of problem-solving methods in continuing education and commended the concept of building teaching and learning into the work of the health care team.

National variations in response to the continuing education programme were particularly great and, likewise, depended on the national system for health care. Professional resistance to change was a major barrier, but health-related research was bringing academics and practitioners together and there was evidence that continuing education could act as an agent of change, for example in relation to prescribing practices.

Discussion focused on three main questions: the impact the WHO programme had in individual countries, how continuing education could be improved and how it could be judged.

The impact of the programme seemed to vary. For example, in Greece it was producing some effect, not so much among physicians where it was informal and voluntary as in nursing, where a responsible (hospital-based) individual in each region ensured that provision was made for continuing education and that it was linked to basic education. In Yugoslavia, the old pre-Alma-Ata pyramid system of health care persisted, of control from a high technology apex down to primary health care [illegible], and difficulties arose because those responsible did not know the problems of primary health care. However, research into health care problems was bringing academics and practitioners together. Sweden was taking WHO policy into account in its planning, and in Finland, the hospital budget included specially earmarked funds. Poland had a centralized continuing education system for physicians, but one major problem was that physicians did not want to move into primary health care work (apparently a very common difficulty). In Spain, many institutions, including schools of nursing, were involved in continuing education, but did not collaborate with one another, and programmes were related to professional interest rather than to needs.

It was agreed that continuing education could be improved only by finding more effective methods. The extent to which continuing education was optional or compulsory depended on the national system and, although it was claimed that requirements, such as the one in Canada, for medical specialists and nurses to undertake courses as a condition for periodic renewal of their licences ensured a higher quality of care, there was agreement that compulsion was not necessarily more productive. Both systematic and less formal methods, such as peer group review or "self-audit", which were neither threatening nor too psychologically traumatic, were required, and there was support for the idea of exploring unorthodox approaches. Finally, continuing education could not be judged satisfactorily without objective before-and-after evaluation which should be built into the system. There was an impression that results so far were disappointing in general, although there was evidence of effectiveness in changing general practitioners' prescribing practices, which encouraged hopes that continuing education could be an agent for change in the near future. The Committee supported the further development of activities in this area and suggested that a WHO study of the effectiveness and efficiency of continuing education should be included in the Seventh General Programme of Work.

(c) Teacher training for the health professions

A review of developments in this field underlined the importance of the earlier meetings dealing with teacher training activities held in San Remo in 1972 and in Warsaw in 1974. The review also stressed the importance of the Seminar on Planning and Implementation of Teacher Training Programmes (London, May 1979). At that meeting, four main issues for teachers of medicine

and health care professionals had been identified: the type of teacher required, the means of finding the right type of teacher (e.g. the proper recruitment and staff development programmes), the desired organizational framework and the nature of evaluation. A Working Group on the Assessment of Competence of Students in the Health Field (Varna, September 1980) had issued recommendations that were distributed broadly to teaching institutions and ministries of health. A Workshop on Educational Planning, held at the Regional Office in 1980, reviewed the present issues in educational development. The review concluded with a list of "priority problems" for 1982-1983:

(1) closer collaboration between countries;

(2) implementation of innovations;

(3) changing programmes to place more emphasis on prevention, PHC and long-term care, reorientation towards community needs;

(4) closer relations between educational and health planning;

(5) the development of departments for training staff in the educational sciences.

The discussion showed that teacher training, which enjoyed the longest tradition and for which a network of collaborating centres existed, was regarded as a success story with clear evidence that the successful contribution of such centres was producing an impact and response at national level. At least in medicine and nursing, teacher training had been steadily developing for the past 25 years, initially in the USA. In Europe, in order to provide the diversity of choice relevant to the Region's needs, WHO had developed these networks instead of regional teacher training centres as was done in other regions.

The development of departments for educational research and development in different medical schools was being promoted by the Regional Office. At present, 70 such departments cooperated with the Regional Office.

The fact that this development was having an impact could be seen from the changes taking place in medical education. For example, a unit for medical education and research had been set up in Budapest and was very much involved in reorienting medical education at the Medical Faculty of the Semmelweis University. In the past 18 months, the Regional Office had organized a workshop on educational planning in Copenhagen and an annual course on modern methodology for teachers of health sciences at the WHO collaborating centre at the British Life Assurance Trust Centre (BLAT), London, in which country representatives had participated jointly with WHO staff members. The activities had proved good experience for staff of the Regional Office who had learned about real situations, and for the country participants who as a result would spread the message of WHO work and prepare similar national workshops in their own countries and languages.

The most urgent needs in teacher training were to redirect teacher training towards primary health care needs, to develop the practical field elements of training so that methodology was not wrongly applied, and to shift emphasis from methodology to changing attitudes and behaviour. The Committee was also reminded that, as teachers were usually selected on the basis of scientific rather than teaching abilities, means should be found to raise the status of teaching as compared with research. It was felt in general that teacher training activities were proceeding properly but that this important programme area should be further developed.

(d) Training of public health officers

A review was made of the main activities, such as meetings, courses and studies, with particular emphasis on the promotion of training in management skills for health service administrators and health personnel in general. A Working Group on the Education of Managers in Health Services (Düsseldorf, November 1977) could be regarded as its starting point. The recommendations of that meeting focused on promotion of action to improve national and international collaboration in this field.

In 1978, the Regional Office for Europe carried out a study on training patterns for public health medical officers in 12 countries in western and eastern Europe, describing not only existing training systems and prevailing training patterns but also possible areas of change. The study was used as background material for a Working Group on Training of Senior Public Health Administrators (Moscow, June 1978), which reviewed programmes for advanced and continuing education of senior public health administrators.

In 1979 a workshop was held in Vienna on country health programming in European health planning and in management education. Participants recommended country health programming as a useful approach for European countries but stressed that existing WHO guidelines on country health programming should be amended to correspond better to the problems and needs of European health planners. The idea of regional specific guidelines for country health programming, in addition to the guidelines for worldwide use, was subsequently supported by the second interregional Seminar on the subject held in Dubrovnik in 1979, where case studies were presented on the adaptability of country health programming to national health planning in Portugal, Turkey and Yugoslavia.

Furthermore, in July 1979 a Working Group was held in Berlin (West) on the design of training in health planning and management. This working group investigated the feasibility of developing and using module training programmes to intensify training in health management. In addition, an evaluation was made of the nine-month courses for public health administrators held annually at the Central Institute for Advanced Medical Studies, Moscow, in the English and Russian languages and the three-week workshop in managerial health processes, held at the University of Leeds, Nuffield Centre for Health Services Administration, and at the Usher Institute in Edinburgh.

In September 1981, ASPHER had been commissioned to conduct a management study on the training of public health medical officers in the schools of public health, with a view to devising a standard programme or common elements whose application could be evaluated.

In the course of the discussion, it became clear that the scale of activities developed by the Regional Office was very broad and met a wide range of perceived needs for skilled health management, as distinct from those connected with traditional public health and industrial hygiene. There was general agreement on the need to stress training for middle management. It was still too early to judge the modern approach to training public health medical officers in health management, but the new concepts were increasingly being applied and ways were being explored to influence individual institutions, e.g. through collaboration with ASPHER, and to develop uniform frameworks for the health management training programme under the WHO programme on managerial processes for national health development.

(e) Nursing

An outline was given of the seven objectives of the medium-term programme in nursing, approved by the Regional Committee for Europe at its twenty-seventh session in Munich 1977. The seven objectives are in essence to assist countries of the region to improve planning and management of nursing services and manpower at all levels, to develop a body of knowledge and technology in nursing through descriptive and experimental research, to promote nursing input, particularly in PHC, HCE, MNH, MCH/FPL, HED, etc., to secure country involvement in changing attitudes and revising practices, to build up collaboration, to improve communication and to promote the integration of education and practice with research. Stress was given to the role in the implementation of the medium-term programme of the eight collaborating centres in Belgium, Denmark, Finland, France, Poland, Switzerland and the United Kingdom (2) and of the three types of "participating centres" that had accepted various degrees of involvement.

The joint nursing and HMD activities envisaged by the Second Advisory Committee in 1978 had been implemented despite reduced resources. Discussion indicated that encouraging progress had been made. The fact was stressed that ministries of health were usually responsible for nursing education, which was not necessarily the case in medical education. Eight more collaborating centres were envisaged within the next medium-term plan (1984-1989) and the main concern was not to advance too rapidly.

The nursing programme was regarded as imaginative and the system of collaborating and participating centres seemed to be developing well. Natural enthusiasm for extending the concept and the programmes more widely within Member States and more quickly had to be tempered with caution, so as to keep developments under control.

It was also pointed out that, although the nursing unit had been allocated organizationally to the Development of Comprehensive Health Services, further joint nursing HMD activities had been undertaken and good lines of internal communication had been maintained.

5. Activities projected in the health manpower development medium-term programme for 1982-1983

The programme budget for the last two years of the Sixth General Programme of Work was set out under four headings as follows.

(a) Health manpower planning and management, which consists of the promotion of studies on coordination between health services and manpower development, courses for public health administrators and development of continuing education for the health professions.

(b) Educational development and support, which consists of research and educational development, support in the development of a network of educational institutions and a seminar on community and primary health approaches in the basic education of medical and other health professionals.

(c) Programme planning and general activities, comprising programme supporting services, a fourth advisory committee on health manpower development and assistance in health manpower development.

(d) Promotion of training, made up of exchange of information on placement, supervision and follow-up of WHO fellows and evaluation of the regional fellowships programme and training courses.

The nursing programme for the same period has four components: the nursing process, organization of management, education of nurse manpower personnel and resource planning, and is assisted by a biennial advisory committee and liaison meetings with nursing associations.

During discussions under this heading, it was agreed that the plans for the next two years reflected two major concerns of WHO. The first concern was to make the content of its programme more relevant to developments at country level by emphasizing that the function of giving grants and fellowships was secondary to that of acting as a technical cooperation agency, whose primary function it was to provide coordination in international health work and to trigger off appropriate responses. The second concern was to realize the potential for collaboration on the part of both individuals and groups possessing the capacity to effect change within Member States and institutions. Collaboration between WHO and NGOs could, for example, maximize the potential contribution of both in meeting common goals. By lending its authority and prestige to nongovernmental organizations, WHO greatly enhances their influence directly in medical schools and schools of public health and indirectly in Member States, at little cost to itself. In return, the nongovernmental organizations offer exactly the kind of alternative channels identified in the evaluation of past activities as being vital to the application of WHO concepts and techniques at national level.

It was specifically envisaged that AMDE, AMEE and ASPHER would be involved in suitable activities in the above fields.

The budget was clearly modest in relation to the scale of the work and reflected both a reduction in the number of professional staff from three to two and the reduced scale of voluntary contributions from Member States due to the economic situation. The Advisory Committee, through its contacts, should help to offset these constraints by securing more support from individual countries by arranging WHO activities with support in kind at the country level.

Specific recommendations on the implementation of the programme for 1982-1983 have been deferred until the medium-term programme for 1984-1989 is studied, because the programme of work is seen as being a continuum.

6. Proposed activities under the Seventh General Programme of Work (1984-1989) with particular attention to 1984-1985

In the draft programme, five problems existing in Member States of the European Region were identified:

(a) health manpower planning has not been adapted to meet the changing needs of the health care system and the communities it serves;

(b) health manpower education and training indicate a slow pace of reorientation and innovation towards a greater emphasis on primary health care and community needs;

(c) faster development of systematic and appropriate continuing education programmes for all categories of health personnel integrated with national health care systems is needed;

(d) there is a lack of community-focused training programmes providing for multiprofessional training and of a teamwork approach to the provision of primary health care;

(e) the type of fellowship training provided is not always relevant to the real health priorities of the country concerned.

For each objective, there were a number of targets which proposed suitable timing and defined approaches.

The Advisory Committee accepted the content of the entire programme and felt that priority should be given to problem areas (a) and (b), together with the necessary provision of relevant and effective assistance and support for the development of activities foreseen at country level. It noted, with some scepticism about its true feasibility, that the programme objective for 1989 was for all countries to have formulated a health manpower planning policy as an integral part of national health policy, with corresponding educational programmes and the development of management capacity to make the maximum use of resources. The need for integration of the various elements in the HMD programme was repeatedly stressed. The Advisory Committee thought that there were two omissions from the programme. One was the need for teachers' reorientation courses on the concept of HFA/2000, with specific reference to the needs of students, other than WHO fellows, from other parts of the world. Secondly, concern was expressed that students receiving basic education in health related fields, e.g. social scientists, social workers and economists, should be taught more about modern strategies for health; at the same time, it was unclear whether the topic fell within the scope of the programme.

The proposed timing schedules were accepted except in the area of reorientation of basic education. In that field it was agreed that the Working Group to Evaluate the Impact of Community-Oriented Teaching Programmes,[a] should be brought forward from 1987 to 1985 and that the report on teacher training activities in the European Region (Op. cit., section 2.1.5, p.15) should be completed as soon as possible and followed up by a seminar on teacher training.

7. Machinery for implementation of the HMD programme

The different types of machinery available to the Regional Office for Europe for implementation of its HMD programme were reviewed. At the regional and subregional levels, there were regular and continuing joint activities with AMDE, AMEE, ASPHER, Nordic Federation for Medical Education (NFME) and the International Council of Nurses (ICN) as well as with intergovernmental bodies such as the Council of Europe (CE), the Commission of the European Communities (CEC) and the Council for Mutual Economic Assistance (CMEA). Within the Region there were collaborating and participating centres which operated on a basis of mutual interest or under contractual agreements. Other kinds of activity consisted of meetings and working groups on specific technical areas of work. These activities, together with the recruitment of consultants and temporary advisers, gave a picture of the broad variety of approaches used to implement the planned activities. The system worked well in matters within the competence and concern of ministries of health, but alternative focal points in other ministries, agencies and institutions were required in individual Member States to implement activities and establish channels of communication.

8. Association for Medical Education in Europe (AMEE)

In a report on the activities of the Association, it was noted that AMEE has assisted WHO in medical educational research and had entered into an agreement with the Regional Office to provide documentation on specific aspects of medical education. A report on the selection of medical students had recently been completed. The collection of data on admission procedures to member schools in European countries had been completed and the report prepared. AMEE was in a position to influence ministries of health to accept the need for a reorientation in medical education. The Association enjoyed close contact with the ministries via its national associations, through which it also had direct contact with medical teachers. Arrangements existed for contacts with medical teachers in those countries of Europe where national associations for medical education had not yet been set up. Such contacts were of particular importance for countries where medical education was under the jurisdiction of ministries of education.

[a] Health manpower development (HMD) medium-term programme for the Seventh General Programme of Work. Copenhagen, WHO Regional Office for Europe, 1981 (unpublished document ICP/PPM 003(2)C), section 2.1.2, p.15).

9. Association of Medical Deans in Europe (AMDE)

In a review of this body's activities, it was stated that the Association, founded two years previously on the initiative of AMEE, was developing rapidly and provided a forum for discussion by deans on educational policy matters. The results of the present Advisory Committee meeting would be communicated to AMDE members with information on how WHO could assist individual medical schools, and the relevant recommendations would be followed up at the next AMDE conference. Initiatives by AMDE and AMEE should help to fulfil the wish of the Advisory Committee for closer links to be forged between medical schools and ministries of health and education if individual deans and other influential teachers made full use of their contacts.

10. Association of Schools of Public Health in the European Region (ASPHER)

The Advisory Committee was told how ASPHER also owed its conception in 1966 to WHO. Members of ASPHER included institutions and departments of social preventive and community medicine with significant postbasic training programmes. Its activities illustrated the clearing-house function of nongovernmental organizations with reciprocal advantages for communication and collaboration between individual members and WHO. ASPHER had contributed substantially to specific projects and activities in collaboration with WHO and had been commissioned to conduct a study on training in health services management for public health medical officers. Members of the Association possessed the necessary expertise to increase their contribution to the future HMD programme, especially in the evaluation of changing needs, new approaches and outcomes.

The potential contribution of NGOs was obviously considerable, but the Committee identified their major shortcomings as being the uneven geographical distribution of their membership, strongest in the western and northern parts of the Region, mainly for historical and administrative reasons. It was agreed that their capacity for effective collaboration with WHO would be greatly strengthened by the involvement of more colleagues and institutions in eastern Europe which would enrich future exchanges of experience.

11. Recommendations

The Committee's recommendations relate to (a) the overall programme and (b) to separate subprogrammes and lines of development for the years 1984-1989.

(a) Overall programme recommendations

(1) In view of the importance of a proper and relevant development of human resources to the implementation of the European strategy for HFA2000, the Regional Office programme on health manpower development should receive full support both for the preservation of high professional competence, for a proper and competent staffing pattern and for the funding necessary for external activities, including close collaboration with NGOs active in the field of medical education and research.

(2) The Regional Office should be encouraged to preserve full continuity of the activities foreseen in the 1982-1983 programme budget and those planned for the years 1984-1989.

(3) The individual targets in all the lines of development for the MTP/HMD for 1984-1989 should be examined in an attempt to identify closely related or common elements appearing under different lines of development in order to facilitate their coordination.

(4) Evaluation should be an integral part of every programme, so as to ascertain whether policies are understood and applied. This objective requires the provision of relevant information and data from those involved to assist independent observers who might be recruited more frequently through NGOs to make objective evaluation.

(5) Increased efforts should be made to include in the HMD programme activities for health professionals other than doctors and nurses, e.g. environmentalists, physiotherapists, nutritionists, psychologists, medical social workers and medical sociologists.

(6) Appropriate training in management, with particular reference to the PHC approach, should be included in postbasic and continuing education of health care personnel, including scientists, who are likely to assume managerial responsibilities in the health services and in academic and research units.

(7) Collaboration with NGOs should be maximized with special reference to the need to strengthen their activities in countries that are passive or resistant to developments in health manpower.

(8) WHO should strengthen the dissemination of information on all its HMD activities to Member States by every available means, including official communications with ministries of health and the use of nongovernmental channels, e.g. AMDE, AMEE, NFME and ASPHER, to show what it can offer in support of programmes in individual countries, including innovative approaches.

(9) WHO should undertake fact-finding exercises to ascertain whether policies and approaches agreed on are known, understood, accepted and applied in health manpower developments, e.g. by schools of medicine, nursing and public health.

(10) WHO should firmly emphasize that its primary function is to provide coordination in international health work rather than to distribute "largesse" which it does not possess.

(11) WHO should explore means of encouraging Member States to take initiatives in seeking advice from the Regional Office in any aspect of HMD.

(12) WHO should seek additional support from grant awarding agencies, both for its own activities and for collaborative work with NGOs.

(13) WHO should explore and employ all channels of communication with the public, including the provision of information in a popular form.

(b) Recommendations relating to the MTP/HMD subprogramme areas foreseen for the years 1984-1989

The rational use of health manpower planning

General recommendations

(1) The importance of the intersectoral approach needed should be emphasized repeatedly in every activity.

(2) The requirement for a functional integration of health services and education at country level must be stressed by every available means.

(3) The pace of the extension and development of the nursing programme requires continued consideration, so that national activities geared towards improving the quality of nursing care, particularly in primary health care, can be supported adequately by WHO whenever requests are formulated.

Specific recommendations

(1) In the production of guidelines and pilot studies, concern with quality, in terms of producing the relevant types of health personnel, should take precedence over considerations of quantity (Op. cit., sections 1.1.3 and 1.1.4, p.14).

(2) Training in health manpower planning should be provided jointly for administrators and academics (teachers and researchers). Whilst it should be interdisciplinary, thought should also be given to whether it should be multidisciplinary (Op. cit., section 1.1.5, p. 14).

Reorientation of basic education

General recommendations

(1) WHO should take up the offer by AMDE to communicate the present report of this Committee to deans of medical schools with an explanatory letter, in order to promote reorientation of basic medical education.

(2) Emphasis should be placed upon the continuing need for environmental health control, including new approaches as to what other disciplines, e.g. chemistry and engineering, should contribute.

3. WHO should explore the means of harnessing the enthusiasm of medical students and should encourage them to act as agents for change in the reorientation of health care and medical education.

Specific recommendations

(1) Epidemiological expertise is required in the evaluation of community-oriented teaching programmes and ASPHER's resources should be employed for this purpose (Op. cit., section 2.1.2, p.15).

(2) In the training of national staff in educational planning and technology, the emphasis should be shifted from methodology to attitudes and behaviour changes, and NGOs should be invited to collaborate as planned (Op. cit., section 2.1.4, p.15).

(3) The working group to evaluate the impact of community oriented training programmes (Op. cit., section 2.1.2, p.15) should be brought forward from 1987 to 1985 and the report on teacher training activities in the European Region (Op. cit., section 2.1.5, p.15) should be completed as soon as possible and followed by a seminar on teacher training.

Continuing education

General recommendations

(1) Studies should be made of the effectiveness and efficiency of continuing education in relation to the needs of individual countries with assistance from NGOs.

(2) Studies should be made of machinery to encourage members of health care teams to meet regularly as an educational activity and to promote training in health manpower management at the primary health care level (Op. cit., section 4.1.5, p.17).

(3) Collaboration with NGOs should be broadly used to acquaint teachers of the health professions with the concept of HFA2000.

Specific recommendations

(1) In developing guidelines on methodology, consideration should be given to the use of a variety of methods (Op. cit., section 3.1.2, p.16) in order to meet the wide diversity of educational needs within different organizational settings.

(2) There should be an attempt to strike a balance between systematic, formal approaches, such as courses and teaching packages and the encouragement of individual and group initiatives, e.g. "peer review" and "self-audit", to make methods more acceptable.

Multiprofessional training programmes

General recommendations

(1) An attempt should be made by WHO to identify common factors in the health problem-solving process in different professions.

(2) Within the programme, emphasis should be placed on practical problem-oriented training.

Specific recommendation

(1) Evaluation of the introduction of interdisciplinary training modules required before and after studies should be made with AMEE and ASPHER assistance (Op. cit., section 4.1.4, p.17).

The development of the WHO fellowship programmes

General recommendation

(1) Efforts should be made to promote a WHO fellowships programme that is more relevant to the primary health care strategy than to the requirements of high technology, and WHO collaborating centres should make special contributions towards such training programmes.

Specific recommendation

(1) NGOs should be invited to assist WHO in making an evaluation of fellowship programmes demonstrably independent and unbiased (Op. cit., section 5.1.4, p.18).

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